Student Health Registration Form 2019-2020

Child's Name_____ _____ _____ _____
First Last Grade Date of birth

In order to ensure the health-safety of students at OSL, we are asking for any ALLERGIES or other MEDICAL CONDITIONS which should be brought to the attention of the staff.

☐ **My child has NO known ALLERGIES or MEDICAL CONDITIONS**

MEDICAL CONDITIONS

Please check if you have ever been told by a physician or health care professional that your child has:

☐ Asthma ☐ Seizure disorder ☐ Bleeding disorder ☐ ADHD ☐ Hearing loss ☐ Eczema
☐ Diabetes ☐ Skin condition ☐ Heart condition ☐ Vision (wears glasses/contacts)

Please provide information as needed:

_____

_____

ALLERGIES* (please list specific allergy)

Food(s) _____
Plants _____

Animals _____ Medication _____
Bees/Insects_____

Seasonal _____Other_____

Please describe the allergic reaction and the **treatment** for **each** checked allergy.

_____
_____
_____

Please notify the staff of any changes concerning any allergy or medical condition of your child.

MEDICATION

Does your child take any medication on a regular basis? Yes* ◯ No ◯ If yes, name of

medication(s)_____

Purpose_____

medication(s)_____

Purpose_____

Will medication be needed at school? No◯ Yes*◯ (Complete Medication Authorization Form)

*Please call to schedule a time to speak with the teacher and/or principal if specific information will impact your child, especially during the school day.

_____ _____
Parent signature Date

Emergency Procedure and Medical Release Form *2019-2020*

Child's Name _____ *Grade* _____

I, _____ certify that my child is in good health and can participate in all normal activities of the group and that I have noted any exceptions below.

I understand that reasonable measures will be taken to safeguard the health and safety of the boys/girls and that I will be notified as soon as possible in case of emergency. However, in the event of sickness or accident, I will not hold the group leaders of Our Savior Lutheran School responsible. In the case of sickness, or accident, after reasonable attempts to reach us or an emergency contact person fail, we, the undersigned parents of _____, minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general special instructions of any licensed qualified physician, whether such treatment is rendered at the office of a physician or licensed hospital. It is understood that consent is given in advance of any specific diagnosis or treatment being required but is given to encourage chaperones of Our Savior Lutheran School and said physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment. I authorize the calling of the physician and/or the providing of other medical services at my expense.

_____ _____
Date Signature of Parent/Guardian

Emergency Contacts (please put a * for parent contact priority):

Name: _____ Circle One: Father Mother Other_____

Work Place: _____ ____

Phone: (____) _____ (Cell) (____) _____ (Cell)

Name: _____ Circle One: ○ Father ○ Mother ○ Other_____

Work Place: _____

Phone: (____) _____ (Cell) (____) _____ (Cell)

Individual(s) to notify in case of emergency if parents cannot be reached.
Please mark the box if the individual(s) is/are also **authorized to pick up child on days in addition to an emergency.**

Name	Relation	Phone (Home)	Phone Home
Name	Relation	Phone Home	Phone Home
Name	Relation	Phone Home	Phone Home

Physician Information:

Name	Address	Phone Number